

Case Number:	CM15-0098250		
Date Assigned:	06/12/2015	Date of Injury:	04/21/1997
Decision Date:	07/17/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/21/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas, California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 61 year old female, who sustained an industrial injury on 04/21/1997. She reported fracturing her tibia and fibula after a fall at work in October 2014. The injured worker was in a rehabilitation facility at the time of the progress note below. The injured worker was diagnosed as having status post fracture of right femur on 8/8/2014 and status post fracture of right tibia and fibula. Her right knee prosthesis had become infected. Treatment and diagnostics to date has included physical therapy, right total knee replacement, right femur surgery, and medications. In a progress note dated 02/17/2015, the injured worker presented with complaints of severe pain affecting both shoulders. Objective findings include being unable to stand or ambulate with virtually absent range of motion in her right knee. The treating physician reported requesting authorization for a power chair, home health care, electromyography/nerve conduction velocity studies of the right upper extremity, and physical therapy of the lumbar spine. The patient's surgical history includes ankle fusion and right total knee replacement and right femur surgery on 8/8/14 and on 10/22/14. Patient has received an unspecified number of PT visits for this injury. Patient sustained the injury due to a trip and fall incident and had history of fracture of tibia and fibula and femur. The medication list includes Percocet, Cymbalta, Norco, Celebrex, Flexeril, Lyrica and Temazepam. The patient has used a cane and walker and wheel chair for this injury. The patient pays neighbor for home assistance. Per note dated 5/4/15 patient had complaints of right knee weakness and difficulty in walking. She was walking with a walker and had no pain in LE and had significant pain in bilateral arm. Detailed physical examination of the bilateral UE was not specified in the records provided. Physical examination revealed no tenderness on palpation and painless ROM of the right knee. Per a note dated 3/11/15, the pt had right biceps area pain, in the area of the PIC line for several months.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Power chair (rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Power mobility devices (PMDs) Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Integrated Treatment/Disability Duration Guidelines Knee & Leg (updated 05/05/15) Power mobility devices (PMDs) Durable medical equipment (DME) Wheelchair.

Decision rationale: Per the CA MTUS chronic pain guidelines cited below, Power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Per the ODG cited below, power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. (CMS, 2006) Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. Physical examination revealed no tenderness on palpation and painless ROM of the right knee. A detailed neurological exam demonstrating significant weakness of the upper and lower extremities or any other medical conditions that will compromise the patient's ability to ambulate by herself or with the help of a walker or cane is not specified in the records provided. Significant functional deficits of the lower extremity that would require a scooter/ power chair were not specified in the records. The absence of a care giver who can propel a manual wheel chair was not specified in the records provided. Inability of the patient to ambulate with canes or other assistive devices was not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. Detailed response to previous conservative therapy was not specified in the records provided. The medical necessity of the request for Power chair (rental or purchase) is not fully established in this patient.

Home health care for 5 hours/day x 7 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: Per the CA MTUS guidelines cited below, regarding home health services, medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Any documented evidence that he is totally homebound or bedridden is not specified in the records provided. Any medical need for home health service like administration of IV fluids or medications or dressing changes is not specified in the records provided. Homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not considered medical treatment. The presence or absence of any family members for administering that kind of supportive care is not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. The records submitted contain no accompanying current PT evaluation for this patient. Detailed response to previous conservative therapy was not specified in the records provided. Previous conservative therapy notes were not specified in the records provided. The medical necessity of the request for Home health care for 5 hours/day x 7 days is not fully established in this patient.

EMG/NCS of the right upper extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: Per the ACOEM guidelines cited below, For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In a progress note dated 02/17/2015, the injured worker presented with complaints of severe pain affecting both shoulders. Patient has received an unspecified number of PT visits for this injury. The patient has used a cane and walker and wheel chair for this injury. The use of these items requires the use of the upper extremities. She was walking with a walker and had no pain in LE and had significant pain in bilateral arms. Per a note dated 3/11/15, the pt had right biceps area pain, in the area of the PIC line for several months. It is necessary to do electro-diagnostic studies to further evaluate the cause of the symptoms in the upper extremities. This information would guide further management. The request for EMG/NCS of the right upper extremity is medically appropriate and necessary for this patient at this time.